Consultation Results #17343960 continued.

Sometimes get shooting R jaw, back of neck, "shoots up back of head" 8-9/10 pain. Lasts about a min. Currently on indomethacin.

Says he doesn't feel rested in ams. Snores sometimes, wife sleep separately to care for young kids. Feels tired during the day but doesn't nap. Drinks caffeinated drinks to stay awake.

Sees private neurologist in Fairbanks, Dr. Martino who is unsure of HA type - thought migraine vs post surgical HA, tried gabapentin, amitriptyline, carbamzepine - but too sleepy. Lastly tried indomethacin -> skin rash

Has tried a lot of nonmedcal therapies, with marginal success: acupuncture, somatic exercises, physical therapy, "chi" magine

Meds tried so far:
Abortives:
Excedin - worked initially
acetaminophen - didn't work
Zomig - helped some
Imitrex - helped some
diazepam - for sleep
tramadol - didn't work
Fioricet - temporary relief
cyclobenzaprine -
Vicodin - nausea
Percocet - nausea

Preventives:
gabapentin - sleepy
amitriptyline - very sleepy, but helpful
carbamazepine - tired, some relief

Allergy meds: fexofenadine, Zyrtec - not helpful

PMH:
pituitary adenoma transphenoidal resection, Madigan 2007
chronic HA
IMJ R
neck stiffness at times (snowboarding and car accident)

FAMILY HISTORY: father has migraine,

SOCIAL HISTORY: lives in Fairbanks, drives a truck, married, 2 kids (5yo and 2 mo old

HABITS: never smoked, occas. ETOH - but worsens HA, denies illicit drugs

ALLERGIES: none known

Consult Request: Consult

Consult No.: 2250927

Consultation Results #17343960 continued.

Neuro Exam:
normal speech content and production

Cranial Nerves:
visual fields: full to confrontation
extraocular movements: full w/o nystagmus
facial sensation: intact LT V1,2,3
face movement: symmetric
hearing: hears finger rub B
soft palate: elevates symmetrically
tongue: midline

Motor:

	Delt	Bic	Tric	Grip	WE	WF	intrinsics	HF	Quad	Ham	DF	PF
R	5											
L	5											

Pronator drift: absent
Tone: normal B UEs

Romberg: mild sway

Coordination:
finger to nose: fast/accurate
heel to shin: intact
tandem walk: intact

Reflexes:

	biceps	triceps	patella	Achilles
R	2	2	2	2
L	2	1	2	2

Gait: narrow based, steady, symmetric arm swing

Musculoskeletal: trigger points in L trap, R post. neck

A/P:
Seen and discussed with Dr. Millican.
Chronic HA since 2007, probably multifactorial r/t migraine (+ fam. hx), brain surgery, myofascial trigger points, R TMJ, poor sleep.
1. Sugg. trial of nortriptyline (less sedating than amitriptyline), build as tolerated to max dose of 150mg/d - stay on max dose for at least 3 months to determine efficacy. If no better consider verapamil or propranolol (try each for at least 3 months to determine efficacy.
2. Support use of measures to reduce HA, better sleep - consider test for sleep apnea, avoid overuse of caffeinated drinks, consider biofeedback, work day shift, exercise.
RTC prn.

PROBLEM LIST/PMHx:

Consult Request: Consult

Consult No.: 2250927

Consultation Results #17343960 continued.

No active problems in computerized problem list as of 5/18/09@09:10

Meds:
Ranitidine
Indomethacin 25mg cap, 2 cap q am

CCs:

/es/ Judith M. Ozuna, ARNP
Nurse Practitioner, Neurology
Signed: 05/18/2009 10:38

(Added Comment)
Entered by: BAKER,DIANE K RN - 02/13/2009 11:47 am HST
Responsible Person: BAKER,DIANE K RN
Entered at: ALASKA VAHSRO

Alert to Dan Plascencia: please schedule new patient appointment with Dr. Meekins. Thank you.

(Added Comment)
Entered by: PLASCENCIA,DANIEL - 02/18/2009 9:49 am HST
Responsible Person: PLASCENCIA,DANIEL
Entered at: ALASKA VAHSRO
Received by Dan. DP.

(Forwarded Comment)
Forwarded from: ANC NEUROLOGY
Entered by: BAKER,DIANE K RN - 02/18/2009 10:26 am HST
Responsible Person: MOFFETT,TYLER C MD
Entered at: ALASKA VAHSRO

Forwarding to ICS - please consider referral to other VA facility (Seattle?) for completion of this consult. ANC Neurology will be unable to meet 30-day timeline criteria for this OIF/OEF veteran. Please see full discussion above.

(Added Comment)
Entered by: BAKER,DIANE K RN - 02/18/2009 10:30 am HST
Responsible Person: BAKER,DIANE K RN
Entered at: ALASKA VAHSRO

Discussed above with Judy Burgos-Farley.

Clinical Notes Report
12/10/2009-CON-ENDO-Rodolfo Argueta-MCS

CHIEF COMPLAINT/PURPOSE OF VISIT:
Age 27. History of a pituitary tumor. Headaches. Here for an evaluation at the request of Dr. Gary Grove.

HISTORY OF PRESENT ILLNESS:
Mr. Olsen, age 27, came to this institution from North Pole, Alaska, with a history of chronic headaches which started sometime in early 2007. They persist, and was seen by the Neurology Department here, and I have reviewed their note as well.

Sometime in the middle of 2007, as a part of the workup for the headaches, a magnetic resonance imaging was obtained and an incidental finding of macroadenoma of the pituitary gland was found. I reviewed report of an MRI in July of 2007 in which the measurements were 3.1 x 1.6 x 2.5 cm with projection toward the right cavernous sinus. In retrospect, he also had visual cuts in the right (hemianopsia) which improved dramatically and is back to normal after surgery.

The surgery was performed at Madigan Medical Center, a military hospital in Seattle, Washington, with success. Report of magnetic resonance imaging obtained thereafter and a couple of them since reveal no recurrence. The impression of the last one, dated November 6, 2008, reads "stable MRI of the brain and of the sella compared with April 2008, with stable post-surgical appearance of the sella. No recurrent pituitary mass evident. No acute intracranial abnormalities detected otherwise."

Prior to the surgery, he appeared to have had an intact pituitary function by the tests that I review in rather voluminous outpatient data he brought with him, and this included a thyroxine, TSH, testosterone, LH and FSH, and an a.m. serum cortisol. I did find that there was an IGF-1 which was initially elevated (somatomedian) to 684, but when checked thereafter it was 389, this after the surgery, but he did not have any symptoms or signs of acromegaly, and the human growth hormone was normal. I did not find any subsequent measurements. More recently, he may have noticed intermittent partial erectile dysfunction, but the overall function is still fine, and his serum testosterone is felt to have been drifted downward slightly but still very much within normal limits. They measured also a sex hormone-binding globulin which is normal.

Presently, he has no symptoms or signs of any pituitary insufficiency otherwise. He does have some increased urination during the day and 2 or 3 times during the night, but no clear-cut increased thirst. I review in the record to see whether there was any evidence of complete or partial diabetes insipidus after the surgery, but I found none. The current history is not suggestive of DI, but this will be looked into.

The headaches persist. They are mostly now in the right side of the face and skull, and have been felt elsewhere and here not to be related to the pituitary tumor history or presence of it (and I agree).

He has been given, prior to starting Topamax, a course of Medrol Dosepak and took 40 mg 48 hours ago and the lesser amount later on, and still is in the process of the taper. I mention this because it will be of relevance in the testing that I wanted and could not obtain (a.m. serum cortisol for instance) and the possibility that a TSH be suppressed by the steroids.

PAST MEDICAL/SURGICAL HISTORY:
1. Resection of a pituitary macroadenoma August 2008.
2. Sinus surgery December 2008.
3. Jaw surgery right side.

Otherwise, he has had no major illnesses or surgeries.

ALLERGIES:
NKA.

EXHIBIT 10
Page 84 of 106

SOCIAL HISTORY:

He is married, has one child. Does not smoke, and may have three alcoholic beverages a month at most.

FAMILY HISTORY:
There is no history of an active endocrinopathy.

CURRENT MEDICATIONS:
As per the current list, which I reviewed. No significant additions.

SYSTEMS REVIEW:
General: He feels generally well, although he does not exercise as much as he used to, but he is still actively working, driving a truck and occasionally mowing lawns.
HEENT: His visual fields are back to normal as per former visual fields, and I saw the report of it.
Cardiovascular: Negative.
Respiratory: Occasional bronchitis in the past.
GI: He does have some reflux and is taking a proton pump inhibitor for it.
GU: His libido is normal, although he occasionally has noted lesser quality of erections, but the overall function is still fine. He does have some increased urination during the day and some nocturia, and as well as dribbling, and will be seeing a urologist for it.
Musculoskeletal: Negative.
Neuro: The headaches. See Neurology note.

VITAL SIGNS:
Height: 174 cm, Weight: 75.1 kg, BMI: 24.81 kg/m^2, BSA: 1.91 m^2

PHYSICAL EXAMINATION:
General: He looks well, healthy, with good muscle bulk (he used to exercise in this regard).
HEENT: Fundi benign. Visual fields normal upon confrontation.
Neck: The thyroid gland is normal in size and consistency.
Lymph Nodes: None palpable.
Cardiovascular: No carotid bruits. There is no edema. Heart normal.
Lungs: Clear to auscultation and percussion.
Abdomen: Negative.
Musculoskeletal: Normal.
Skin: There is no increased or decreased pigmentation. Good texture.
External Genitalia: Both testicles are normal in size and have a normal consistency as well.

IMPRESSION/REPORT/PLAN:
Diagnoses:
#1 History of a pituitary macroadenoma, resected.
Most likely intact pituitary function.

#2 Headaches, migraine syndrome.

#3 History of esophageal reflux, on therapy.

Plan and Counseling: I do not think that the headaches are related to the pituitary tumor which in fact is pretty much resected by now, although I suspect that there must be remnant in the cavernous sinus, as it was there to begin with, and I do not think the surgeon would have been able to resect it in that area.

To the best of my knowledge, there was not any increased production of any pituitary tumor to begin with. There was the transient suspicion of an abnormal IGF-1, but this was not confirmed, and the patient does not have any symptoms or signs that would be suggestive of acromegaly.

I will try to review here an a.m. bioavailable testosterone with an FSH, as well as another set of growth hormones and IGF, and he will give in the fasting state, including fluids (12 hours), a sample for serum osmolality and urine osmolality, which I expect to be normal. Otherwise, I will comment further.

He is leaving this weekend, so I will not see him for a return visit, but I will send him not only this note

but a further one with my comments regarding the laboratory data, so he can distribute the information among his physicians up North. I will most likely give him a telephone call as well to let him know about the results some time next week.

DD: 12/10/2009 09:55
DT: 12/10/2009 10:11
JOB#: 1483529

GENERAL NOTE INFORMATION:
Provider: Rodolfo Argueta MD
Referred By: Dr. Gary Grove.
Status: Trx
Transcription Date: 12/10/2009 10:11 AM
Last Revision Date: 12/10/2009 6:20 PM

Clinical Notes Report
12/10/2009-THE-PSI-Duane Hurst-MCS

CHIEF COMPLAINT/PURPOSE OF VISIT:
Patient seen at the request of Dr. Halker with regards to his chronic migraine headaches.

HISTORY OF PRESENT ILLNESS:
Patient is a pleasant 27-year-old gentleman from Alaska. He presents here promptly for today's encounter. The patient reports an unrelenting headache that varies in intensity from 4 out of 10 to 10 out of 10. As noted in Dr. Halker's report his headaches tend to vary in their characteristics. By his report, he was not pleased to hear the diagnosis of migraine and continues to be rather skeptical of this diagnosis. I was never quite clear as to what his objections were to the diagnosis apart from his rather subjective impression that it does not seem to be a good fit from his prospective. He reported that he had spoken to his wife earlier today and shared this impression with her as well and in his words she became quite distressed over the phone in hearing this appraisal.

Without spending a great deal of time exploring the issues around whether the headaches are migrainous versus of different etiological sources I suggested to the gentleman that he may very well have the potential for altering the way his brain interprets his pain and incoming pain signals with regards to a number of different sources of pain based on the way he attends or ignores the pain. He clearly understands this concept in that he states that he is relatively unaware of his headache pain when he is driving his all terrain vehicle. Other examples that he sited is when he is engrossed in a video game. On the other hand, when he is simply relaxing about the house without any notable focus for his attention he is inclined to become more aware of his underlying pain. That was a specific concept that I was attempting to exploit with him today as we sought to use autoregulatory techniques to assist him with his pain management. We mutually agreed to engage in a trial of heart rate variability biofeedback today in order to explore its potential for assisting him with pain management.

For today's trial a respiration strain gauge was placed at approximately the diaphragmatic level. Peripheral temperature was taken from the left ring finger. Heart rate sensors were attached to the inner aspect of both wrists. Skin resistance measures were taken from the second and fifth digits of his left hand. During initial baseline, the patient was noted to be breathing at approximately 12 breaths per minute. During the latter stages of this 60 second baseline his breathing became more regular and symmetrical. At that time the covariation of his heart rate to his breathing became much more apparent. This was pointed out to the patient and he was subsequently asked to follow a respiration pacing device set at 6 breaths per minute. He appeared to do so rather easily and clearly began to display a covariation of heart rate vis-a-vis respiratory effort. At the conclusion of this phase of the baseline, the patient was asked for subjective impression of what he experienced when breathing in his manner. Based on his feedback we agreed to quicken the pace for the next trial as well as to de-emphasize the length of time on the expiratory phase. We experimented with various settings until we settled upon the following as seeming to hold notable potential for him: Breaths per minute = 7.8, in =2.8, out = 2.9, with both holds set at 1.0 seconds. Patient complained that his right occipital pain seemed to worsen over the course of today's encounter.

IMPRESSION/REPORT/PLAN:
Assessment:
#1 Migraine headache, 346.70.
Patient was given information concerning downloading the EZ Air Plus Respiration Pacing program via the internet. Frankly, I am doubtful that he will do this. Given the increased pain that he experienced during the course of the encounter today it would be understandable if he were not to pursue this. Nonetheless I did provide him with the information as to how he may download the EZ Air Plus program if he were to choose to do so. I provided him with the settings noted above and encouraged him to install them soon. I asked him to practice on a regular basis when his pain was not great in order to develop an overlearned response that he may use in the face of worsened pain. Patient is free to followup with me as needed.

DD: 12/10/2009 16:32
DT: 12/18/2009 14:10
JOB#: 1485574

GENERAL NOTE INFORMATION:
Provider: Duane Hurst PhD
Status: Trx
Transcription Date: 12/18/2009 2:10 PM

EXHIBIT 10
Page 88 of 106

CLINIC

Clinical Notes Report
12/8/2009-CON-N-Rashmi Halker-MCS

CHIEF COMPLAINT/PURPOSE OF VISIT:
Attending Physician: Dr. David Dodick.

Chief Complaint/Purpose for Consult: Headache.

HISTORY OF PRESENT ILLNESS:
The patient is a 27-year-old, right-handed male with past medical history significant for pituitary tumor that was resected in August of 2007 as well as acid reflux and hyperlipidemia. He presents accompanied by his father from North Pole, Alaska, for evaluation of headaches. The patient provides his own history.

The patient tells me that he developed "a normal" headache on the top of his head in May or June 2007 and began losing his peripheral vision soon after. He underwent an MRI of his brain which demonstrated a pituitary tumor which was resected transsphenoidally in August 2007. The patient was taken off of steroids about two months later and at that point developed a headache. The patient tells me that his headache is mainly located over the bilateral occipital head region, the right temporal head region and the vertex of his head. He describes the pain as being throbbing, dull, annoying, and tells me that it is mild to moderate in intensity. He has also developed pressure pain over the right jaw and over the sinuses on his face bilaterally, and pressure pain around his eyes. Often these two pains, the headache and the facial pain, will occur together, but sometimes one can be present without the other. However, if he does develop the facial pain this will often trigger worsening of the headache and vice versa.

In addition, the patient tells me that two to three times a day on most days he will have lancinating pain that will begin at his right jaw and radiate to the right occiput and the right temple. This lasts less than one minute. It is a shooing pain of severe intensity. However, the patient feels that this is not his biggest problem. The headache and facial pain described above are what he feels affects his quality of life the most.

The patient admits to scalp allodynia. He relates an incident to me recently when he had his haircut and when the woman was cutting his hair and combing his hair he felt this to be quite uncomfortable.

The patient denies any postural component to his headache.

The patient denies any autonomic features to his headache.

The patient does admit to photophobia, phonophobia, and osmophobia accompanying his headache as well as sore and stiff neck and some anxiety. He finds relief while lying down in a dark, quiet room with a cold compress on his head.

The patient has noted that hunger can bring on a headache and eating will help improve it. He also find that any sort of disruption to his sleep cycle, such as getting too little sleep or too much sleep can also bring on or worsen his headache. Other precipitants include fatigue, sex and orgasm sometimes, physical exertion, coughing, chewing, stress, loud sounds, bright lights or sun, and odors.

The patient denies any aura prior to headache onset.

The patient tells me that if he is concentrating on something he will not notice his headache and will have actually no head pain at all. However, if he is sitting around watching TV or doing nothing, then all of a sudden he will notice his headache again. Despite this, he also tells me that if he is sitting around relaxing or doing nothing, he will also have periods in which he is headache-free. He feels that his headaches will last about an hour to two and then it remits for possibly a half an hour to an hour and then come back again.

The patient's prior workup includes seeing his neurologist at home in Alaska, seeing a neurologist in Alabama, a neurology nurse practitioner at the VA Hospital at Puget Sound in Washington, and undergoing

a lumbar puncture in January 2009 which showed mildly elevated protein (in the 50s), but was otherwise negative. The patient also tells me he underwent a CT myelogram which was negative for a CSF leak in January of 2009.

The patient tells me that he has tried gabapentin at a dose he thinks 200 mg twice a day. This led to fatigue and did not help his headache. He also has tried carbamazepine at a dose unknown, which did not help. Valium and cyclobenzaprine did help him sleep a little bit, but otherwise were not helpful. The patient did try amitriptyline which seemed to give him some headache relief up to a dose of 17 mg, at which point it made him quite groggy to the point that he was not able to function and no longer helped with his headache. About six months ago the patient was placed on nortriptyline and reached a maximum dose of 75 mg at which point he developed fatigue and it no longer helped his headache either. About three weeks ago he dropped the dose down to 50 mg at bedtime, but does not find that this adequately controls his headache.

The patient had tried indomethacin in the past at a dose of what seems to be 50 mg in the morning, which the patient is not sure of what it did. He has also tried Fioricet, Imitrex, nasal spray, Tylenol, naproxen, Zomig tablets, Excedrin, and tramadol, all of which helped a little bit initially but then stopped working. The patient also has Percocet and Vicodin available to him at home. He last used these in December 2008. He tells me that the Percocet and Vicodin do help his headache, but lead to an upset stomach and so he does not take them.

The patient tells me that he was given a TENS unit by a physical therapist and will apply this to the right side of his face, and does find that this helps improve the intensity of his pain.

The patient has tried acupuncture which became cost prohibitive and it is not clear if it really helped. He also saw a chiropractor, tried physical therapy, and allergy testing, none of which helped. The patient last had an eye exam on April 10, 2009 and dental evaluation in October of 2009 and was told that things were fine. The patient also had his sinuses worked on and he tells me that they cleaned out some scar tissue, but this did not thing for his headaches.

The patient's last brain MRI is from November 2008. He also had sinus x-rays done in December 2009 and June 2008.

The patient's PHQ-9 score is 11-2. He rated that he feels tired and has little energy nearly every day.

The patient's MIDAS headache disability questionnaire result is 85-90-6, which places in the severe disability category from his headaches.

The patient tells me that prior to his symptoms beginning in the Summer of 2007, he would occasionally get a mild headache, but nothing severe or persistent.

The patient was in the Military and stationed in Germany in about 2003 or so and at that point did develop headaches when he was assigned to working the night shift. It was thought that this was due to eye strain from having to stare a computer screen all day, all night long, and he was given prescription glasses when he sought evaluation for his problem.

PAST MEDICAL/SURGICAL HISTORY:

1. Headaches as described above.
2. Mild hyperlipidemia.
3. Acid reflux.

ALLERGIES:

The patient tells me he is allergic to Tylenol No. 3 as it upsets his stomach. He denies any allergy to x-ray or contrast dye, latex, or tape.

SOCIAL HISTORY:

The patient is married to his wife of eight years. He lives at home with her and their two children. He is a local truck driver at home in Alaska, but had been in the Military previously and stationed in Germany. He

s a lifelong nonsmoker. Admits to using alcohol a couple of times a month. He denies any history of illicit drug use. His caffeine intake consist of two small cups of coffee every morning and on weekends he also would have one to two sodas.

FAMILY HISTORY:
The patient's father has a history of migraine headaches with aura and carries around Imitrex injections with him, which he took out of his pocket to show me. The patient's mother also gets milder headaches, but the phenotype is not very clear. He has one sister, she is alive, in good health, aged 29. She does not get headaches. The patient's grandparents do not have any headache history that he knows about. The patient has two daughters, one of whom is five years old and the other is eight months, they are both healthy.

CURRENT MEDICATIONS:
1. Nortriptyline 50 mg p.o. q.h.s.
2. Prilosec one tablet daily.
3. Unisom one tablet every Sunday night. He tells me that if he takes it on Sunday he is able to get up for work on Monday without any difficulty.

SYSTEMS REVIEW:
Constitutional: The patient denies any fevers, chills, or changes in his weight.
Eyes: He denies a history of aura, diplopia, blurred vision, or loss of vision.
Ear, Nose, Mouth, Throat: Negative.
Cardiovascular: He denies any chest pain or palpitations. He tells me that if he stands up too quickly he may feel a little lightheaded.
Respiratory: The patient tells me he had a sleep study and was found to not have sleep apnea. He has never been told that he snores when he sleeps and feels well rested in the morning when he wakes up. He denies any problem or difficulty breathing.
Gastrointestinal: The patient admits to nausea and vomiting if he does not to get at least 8-9 hours of sleep or if his sleeping schedule is off. He denies any constipation or diarrhea.
Genitourinary: The patient denies any history of kidney stones. He does admit to urinary retention, difficulty urinating, as well as post-void dribbling. This started after his pituitary surgery, but tells me that it has gotten worse in the past three months.
Musculoskeletal: Negative.
Neurologic: As stated in the HPI. In addition, the patient tells me that he has had two neck injuries in the past, one was due to a snowboarding accident, and the second due to a whiplash injury in a car accident in which he was rear-ended. He also tells me that if he closes his eyes and tries to walk he feels unsteady. He also admits to some problems with memory in that if he is writing an e-mail or a text message to someone, he will sometimes think about what he wants to write next and finds that he has written the same word three times as he is thinking ahead.
Psychiatric: The patient does admit to anxiety and depression over his current situation and he also tells me that he has become aggressive and easy to annoy at times. He tells me that he can snap at his wife or at his children much more easily than he thinks he should. He was tried on Zoloft at one point and did not find this helpful.
Skin: The patient tells me he is allergic to some types of metal and cannot wear a necklace.
Endocrine: The patient is not a diabetic. He denies having thyroid problems.
Hematologic/Lymphatic: He denies any personal history of malignancy, blood clot, or bleeding disorder.

VITAL SIGNS:
Height: 176 cm, Weight: 77.2 kg, BMI: 24.92 kg/m², BSA: 1.94 m², Temperature: 36.7 °C
Blood Pressure: 141/89 mmHg, Pulse: 88 bpm

PHYSICAL EXAMINATION:
General: The patient is a well-developed, well-nourished, Caucasian male who looks about his stated age of 27. He appeared anxious, but was cooperative.
Psychiatric: The patient appeared quote emotional during the interview as well as anxious, and did cry quite a bit when describing his symptoms.
Musculoskeletal: The patient did not have any tenderness to palpation over his sinuses, scalp, neck, or shoulders. Range of motion was normal at the neck.

Cardiovascular: He has a regular rate and rhythm. No murmurs, rubs, or gallops.
Lungs: Patient's lungs are clear to auscultation bilaterally.
Neurologic: The patient is awake, alert, and fully oriented to his name, home address, today's date, and his current location. There is no papilledema on funduscopic exam, gaze is conjugate in all directions. Pupils are about 3.5 mm in the dark and constricted briskly with light. Visual fields are grossly intact to confrontation. His face is symmetric. His tongue is midline. There is no dysarthria. Hearing was intact bilaterally to finger rub. Pinprick and light touch sensation were intact bilaterally over the patient's face. He has normal strength and tone in all extremities. Deep tendon reflexes were intact and symmetric throughout. Toes were downgoing bilaterally. Sensation is intact to pinprick and vibration in all extremities. Finger-to-nose and heel-to-shin testing was intact bilaterally. The patient has normal station and gait. He is able to ambulate on his toes, heels, and tandem walk without difficulty. Romberg sign is negative.

IMPRESSION/REPORT/PLAN:
Assessment and Plan:
#1 Chronic migraine.
The patient's headache which is mainly right-sided, can be as moderate to severe intensity (the patient states that at a maximum it is 6-7 on a 10-point scale), pulsating, accompanied by photophobia, phonophobia, and aggravated by routine physical activity, meets criteria for migraine. The patient also has a genetic predisposition, given that his father does have migraine headaches with aura and the transsphenoidal pituitary tumor resection may have been what triggered the start of migraines in this patient. Although the patient has responded to tricyclic antidepressants, he complains of urinary retention and consequently we will switch him from his nortriptyline to another medication at this time. I have asked the patient to cut his nortriptyline down to 25 mg at bedtime for one week and then to just discontinue it. In the meanwhile, I have given him a prescription for a Medrol Dosepak and have asked him to take that as directed on the package to help break headache cycle. He tells us that he was placed on prednisone 40 mg at one point for bronchitis and found that the five-day course did help his headaches. The patient did have some concern over aggression, as he tells me that weeks to months after he was taken off of steroids, both initially after the pituitary resection and after the time he was on it for bronchitis, he did demonstrate some increased aggression and anger. I discussed with the patient that those symptoms may be due to his culminating pain and not the steroids as he had been off of them for weeks or months when this aggressive behavior developed. The patient is willing to give the Medrol Dosepak a try. I have also recommended to the patient that we try Topamax as a prophylactic medication for his headaches. I have given him a prescription for 25 mg of Topamax with instructions to start by taking 25 mg at bedtime and then increasing weekly to a target dose of 50 mg twice a day. The intended benefits and potential side effects of this medication were discussed with the patient. If he does noted respond well to the Topamax, there are numerous other options which could be tried, including Depakote, Inderal, Botox, as well as occipital nerve blocks. We have also referred the patient for biofeedback as an adjunctive treatment for his headaches.

#2 Anxiety and depression.
The patient does endorse symptoms of anxiety and depression and was quite tearful, crying profusely at times during the interview due to the impact his headaches have had on his life. We will refer him to Psychiatry for treatment recommendations as he may benefit by being on an antidepressant, such as Cymbalta, for a short period of time.

#3 Urinary retention, post-void dribbling.
The patient has expressed concern over this, says he feels the symptom began after his Foley catheter was removed after his pituitary surgery, but this has worsened on the tricyclic. We will go ahead and refer the patient to Urology at this time to see if any additional studies need to be done to look into this. We will also go ahead and discontinue his tricyclic.

Followup: The patient tells us he will likely not be able to come back down to Arizona for a followup visit with us here in the Headache Clinic, and asked that we simply forward recommendations on to his neurologist at home. I have given the patient a copy of my card and I have asked him to give us a call if we can be of any additional help in the future, as we would be happy to see him back. The patient voiced understanding and agreement.

CLINIC

This patient was seen and discussed with Dr. David Dodick who agreed with the management plan as outlined above. Please refer to his staff note for additional comments.

DD: 12/08/2009 13:40
DT: 12/08/2009 16:36
JOB#: 1479236

GENERAL NOTE INFORMATION:
Provider: Rashmi Halker MD
Referred By: Self.
Status: Trx
Transcription Date: 12/8/2009 4:36 PM
Last Revision Date: 12/9/2009 11:04 AM

Clinical Notes Report
12/8/2009-CON-P-Gary Grove-MCS

CHIEF COMPLAINT/PURPOSE OF VISIT:
Purpose of Visit: The patient is a 27-year-old married Caucasian male from North Pole, Alaska. He was seen at the request of Dr. David Dodick to evaluate and make treatment recommendations regarding depression and anxiety.

HISTORY OF PRESENT ILLNESS:
The patient reports that he had a pituitary adenoma resected in 2007. Postoperatively, he was put on glucocorticoids and he felt good. When they were tapered and discontinued, he developed frequent right hemicranial headaches with associated symptoms as described by Dr. Dodick. He has some level of headache almost 70% of the time. He reports that he began becoming depressed around the time that the headaches began. He reports that when the headaches are mild or absent, he feels good emotionally, but he feels more depressed when he has the headaches. Associated symptoms of depression include restless sleep, decreased appetite, variable interest/pleasure, variable decreased energy, problems concentrating, and an occasional passive suicidal thought without intent or plan. The patient also feels quite guilty about what he cannot do because of his headaches. He has also become more irritable. The patient denies any history consistent with mania/hypomania, psychotic symptoms, or substance abuse.

Concerning anxiety, the patient reports that he probably has been anxious since he was a child. He worries about many things and has a history of mild headaches, difficulty concentrating, and less-frequent sleep disturbance before his surgery. Additionally, the patient has had mild obsessive-compulsive symptoms including rituals as a child and some checking, straightening, and hoarding compulsions as an adult. He has always been somewhat shy and quite anxious during social situations or other situations where he feels evaluated or scrutinized. He denies frank panic attacks or any history of trauma. We reviewed the relationship of stress and his headaches. He reports that stressful situations can bring on headaches and enjoyable, nonstressful situations can lead to resolution of headaches.

Treatment for his headaches has included several psychotropic medications. Currently he is on nortriptyline 50 mg q.h.s., which he states may have helped his anxiety and depression a little bit. In the past he was on amitriptyline, which made him tired, but also helped his mood somewhat. He took diazepam for sleep, but he does not remember how well it worked. He also has taken carbamazepine and gabapentin, both of which caused sedation. For his mood, he was placed briefly on Zoloft, but he did not take it for very long because he did not feel he needed to be on an antidepressant. He feels that if his headaches can go away, his mood will improve.

PAST MEDICAL/SURGICAL HISTORY:
Past Medical History:
1. Pituitary adenoma, status post resection in 2007. The patient has not been evaluated by an endocrinologist, although he knows that he has had low testosterone. He was given a testosterone gel for this, though he is no longer on it.
2. History of right mandibular surgery at age 9 due to lack of symmetry that led to dental problems. He has noted that the headaches radiate to the right temporomandibular region.

ALLERGIES:
No known medication allergies.

SOCIAL HISTORY:
The patient was born and raised in North Pole, Alaska, which is in the Fairbanks area. He reports his childhood was generally happy and he denies abuse of any kind. Educationally, he completed high school. After working for a lumberyard for a year or two, he joined the Army at age 19 and was stationed in Germany. He noted that when he first went in the Army his anxiety increased, particularly due to moving to a strange environment. He has noted that when he does leave his home area, he does become more anxious. He was in the service for four years. When he returned to the United States, he was in Alabama for eight to nine months getting certified to drive a truck, which he has done for the past couple of years. He also felt uncomfortable and more anxious in Alabama. Concerning relationships, he has had two

serious ones. He had a serious girlfriend in high school, and has been married to his wife now for eight years. They have two daughters. His wife has not gotten pregnant since the surgery, for which he feels guilty, blaming it on his low testosterone levels. They have not had fertility testing, however.

FAMILY HISTORY:
The patient reports that his father and paternal grandfather both had problems with anxiety. In addition, his father became depressed when he had a viral illness.

CURRENT MEDICATIONS:
1. Omeprazole 20 mg daily.
2. Nortriptyline 50 mg q.h.s.
3. Fish oil capsules, one daily.

In addition, Dr. Dodick and his fellow, Dr. Halker, who diagnosed his headaches as migraines, recommended tapering off the nortriptyline and starting Topamax. They also wanted to give the patient some short-term relief by giving him a six-day Medrol Dosepak.

PHYSICAL EXAMINATION:
Mental Status Examination: The patient was a pleasant and cooperative, well-groomed and appropriately-dressed 27-year-old white male. He had no abnormalities of movement or behavior. Speech was slightly decreased in volume and tone modulation. Affect was restricted, tearful on a few occasions, and mildly anxious. Mood was depressed and anxious. Thought processes were well organized and goal oriented. Thought content showed no evidence of hallucinations, delusions, active suicidal ideation or homicidal ideation. Cognition: The patient was alert and oriented to person, place, time, and situation. Memory and other cognitive processes were intact grossly. I administered a Beck Depression Inventory and the patient scored 28, suggesting moderate symptoms.

IMPRESSION/REPORT/PLAN:
Assessment:
#1 Depression, NOS.
The patient probably has a mood disorder secondary to a general medical condition, either the headaches or possibly a hormonal imbalance. Low testosterone could be contributing to his depression, as well as hypothyroidism or some imbalance in the HPA axis.

#2 Mixed anxiety disorder.
The patient has a long history of anxiety with features of generalized anxiety disorder, social phobia, and OCD. The anxiety certainly exacerbates his headaches and may contribute to their initiation.

#3 Rule out endocrine abnormality.

#4 Headaches.
As per Neurology.

Recommendations:
1. I think it would be a good idea for the patient to be evaluated by Endocrinology. I placed an order for a consult.

2. Concerning medications for depression and anxiety, the patient is probably going to need long-term treatment for his anxiety. Doctors Dodick and Halker suggested Cymbalta, given its possible pain benefits. This or one of the other SNRIs (Effexor XR, Pristiq, or even Savella) might be appropriate. The usual SSRIs might also help for the anxiety and depression.

3. The patient has been referred for biofeedback training, which will help his anxiety as well as his pain control.

If you have any questions, please feel free to contact me. Thank you for asking me to see this very pleasant young man.

DD: 12/08/2009 15:42
DT: 12/09/2009 15:54
JOB#: 1479384

GENERAL NOTE INFORMATION:
Provider: Gary Grove MD
Referred By: David Dodick, M.D.
Status: Trx
Transcription Date: 12/9/2009 3:54 PM

CLINIC

Clinical Notes Report
12/8/2009-SN-N-David Dodick-MCS

IMPRESSION/REPORT/PLAN:

Justin Olsen is a 27-year-old gentleman from North Pole, Alaska, who was evaluated in the Headache Clinic at Mayo Clinic Hospital on December 8, 2009. I personally met with the patient after reviewing the physical therapy HPI, PMH, meds, allergies, social history, family history, review of systems, and physical findings with Dr. Halker.

The patient has a past history of being mildly and somewhat headachy. He was seen while he was in the military for headaches and was given prescription lenses. His father has a history of migraine with aura.

In June of 2007, he presented with more severe headache and loss of peripheral vision, was found to have a pituitary tumor, underwent transsphenoidal resection, and was placed on steroids thereafter.

When he was finally withdrawn from steroids, he developed recurrent frequent, near daily, right hemicranial headaches associated with referred pain into the temporomandibular joint area. The pain is throbbing, associated with photophobia, phonophobia, scalp allodynia, and aggravation with routine physical activity.

He has been seen by a neurologist in Alaska, has been tried on both Elavil and Pamelor, with some benefit but with significant fatigue and urinary symptoms including retention, difficulty voiding, and postvoid dribbling. He has tried TENS and acupuncture, he has had allergy and dental evaluations, he has been on a dose of indomethacin at 50 mg, and he has tried Valium, Flexeril, gabapentin (fatigue) and carbamazepine. He has not gotten robust results from any medication and most of them have been associated with side effects.

The patient is a truck driver and a father of two young children. He has become more irritable and flies off the handle more easily since his surgery, but this may also be due to the chronic pain, as much as to the steroid to which he attributes the irritability.

The patient's neurological examination is normal. His neck examination today was normal despite the fact that he complains sometimes of a knot in the right cervical paraspinal muscles. We were not able to palpate any areas of tenderness today. His temporomandibular joint exam is normal. There is no tenderness over the temporomandibular joint in the jaw closed or jaw open position.

I believe the patient has chronic migraine. He underwent a transsphenoidal resection, he has a history of headache in the past though maybe not meeting the criteria for migraine. He has a family history of migraine with aura. He now presents with near daily attacks of throbbing, moderately severe or severe, unilateral right-sided head pain associated with photophobia, phonophobia, and aggravated by routine physical activity.

He has responded somewhat to modest doses of tricyclic antidepressants, but fatigue and urinary symptoms limit their use.

The patient admits to being depressed, especially when his headache is severe. He also, however, admits to feeling well emotionally when he is not having headache. As long as he is engaged in outdoor and physical activities, he does not notice his pain as much or at all.

We will refer him to Psychiatry and to Psychology. He will undergo biofeedback training, and we will recommend that he stop the tricyclic, begin with topiramate, and undergo a dose titration while maintaining a headache diary. Botulinum toxin occipital nerve block and Depakote are certainly treatments that could be and should be considered if his response to topiramate is not optimal or if he develops intolerable side effects. I tried to tell the patient to remain optimistic, that there is help for him that will reduce his suffering, but it may have to entail a combination of cognitive behavioral therapy, biofeedback, as well as medication.

EXHIBIT 10
Page 97 of 106

We will also refer the patient to Urology as he is having symptoms of both retention and incontinence. This may be due to a traumatic catheterization that he had during his transsphenoidal resection, and made worse by the fact that he is on a tricyclic, but we will ask Urology to see him to determine whether or not any urodynamic studies or cystoscopy is indicated.

Finally, I believe that Cymbalta may be a reasonable antidepressant for him to reduce his anxiety and irritability and to possibly reduce his headaches and augment the effect of topiramate.

DD: 12/08/2009 13:24
DT: 12/08/2009 13:37
JOB#: 1478503

GENERAL NOTE INFORMATION:
Provider: David Dodick MD
Status: Trx
Transcription Date: 12/8/2009 1:37 PM

18 Dec 2009 - Miscellaneous note, Rodolfo Argueta, Endocrinology

Document Originated From: Dolbey Transcription App

IMPRESSION/REPORT/PLAN:

This note pertains to the Endocrine consultation of 12/10/09 when I saw Mr. Olsen, age 27, at the request of Dr. Gary Grove and Dr. David Dodick of the Psychology and Neurology Departments, respectively.

Mr. Olsen's physical examination was unremarkable. The actual imaging of postoperative magnetic resonance imaging with special attention to the pituitary gland, obtained elsewhere, were not reviewed here but a written report of the last one, on 11/06/08, about 16 months after his pituitary surgery, reported stability with stable postsurgical appearance of the sella and no recurrent pituitary mass evident.

During my examination I did not find any physical abnormalities. Specifically, I did not find anything for hypogonadism, and nothing that could suggest acromegaly. His visual fields, at least upon confrontation, continued to be within normal limits.

Because there was some history of possible increased urination with nocturia, I obtained a blood sampling at 8 o'clock after nearly 12 hours of no food and no liquids, an electrolyte panel that was satisfactory. Specifically I am referring to the serum sodium which was 140. The same sample had an osmolality of 295 (normal) and a urine sample suggested that also his osmolality was adequate. That is, I do not think that he has diabetes insipidus even though this was not a formal water deprivation test.

He also had noted partial erectile dysfunction although libido is normal and does not appear to be a major problem now. In any event, his total and bioavailable testosterone are normal, and both FSH and LH are also within normal limits. His serum prolactin is normal. I do not think that he has hypogonadism, either central or primary at this point.

Finally, because prior to the operation, and despite a normal human growth hormone, an IGF-1 (somatomedin) was elevated, I repeated this. It is again moderately elevated at 608 units (normal 117-329). Since the tumor was extending toward the cavernous sinuses, and thus I am sure that there is still some remnant, and despite the absence of any phenotype suggestive of human growth hormone excess, I think that this matter needs to be followed and acted upon if necessary at some point in the future.

I will send this note to Mr. Olsen, as I had discussed with him, with the specific intent of disbursing this information with his physicians, particularly the endocrinologist that is following him.

Diagnosis:
#1 Chronic headaches.
#2 S/p pituitary tumor.
#3 Possible small remnant of pituitary tumor, ?producing excess HGH.

Plan and Counseling: As above.

DD: 12/18/2009 07:36
DT: 12/18/2009 08:27
JOB#: 1501858

Original: RA:tc

10 Dec 2009 - Consultation (SPEC, SURG, DIR), Rodolfo Argueta, Endocrinology

Document Originated From: Dolbey Transcription App

REFERRAL:
Dr. Gary Grove.

CHIEF COMPLAINT/PURPOSE OF VISIT:
Age 27. History of a pituitary tumor. Headaches. Here for an evaluation at the request of Dr. Gary Grove.

HISTORY OF PRESENT ILLNESS:
Mr. Olsen, age 27, came to this institution from North Pole, Alaska, with a history of chronic headaches which started sometime in early 2007. They persist, and was seen by the Neurology Department here, and I have reviewed their note as well.

Sometime in the middle of 2007, as a part of the workup for the headaches, a magnetic resonance imaging was obtained and an incidental finding of macroadenoma of the pituitary gland was found. I reviewed report of an MRI in July of 2007 in which the measurements were 3.1 x 1.6 x 2.5 cm with projection toward the right cavernous sinus. In retrospect, he also had visual cuts in the right (hemianopsia) which improved dramatically and is back to normal after surgery.

The surgery was performed at Madigan Medical Center, a military hospital in Seattle, Washington, with success. Report of magnetic resonance imaging obtained thereafter and a couple of them since reveal no recurrence. The impression of the last one, dated November 6, 2008, reads "stable MRI of the brain and of the sella compared with April 2008, with stable post-surgical appearance of the sella. No recurrent pituitary mass evident. No acute intracranial abnormalities detected otherwise."

Prior to the surgery, he appeared to have had an intact pituitary function by the tests that I review in rather voluminous outpatient data he brought with him, and this included a thyroxine, TSH, testosterone, LH and FSH, and an a.m. serum cortisol. I did find that there was an IGF-1 which was initially elevated (somatomedian) to 684, but when checked thereafter it was 389, this after the surgery, but he did not have any symptoms or signs of acromegaly, and the human growth hormone was normal. I did not find any subsequent measurements. More recently, he may have noticed intermittent partial erectile dysfunction, but the overall function is still fine, and his serum testosterone is felt to have been drifted downward slightly but still very much within normal limits. They measured also a sex hormone-binding globulin which is normal.

Presently, he has no symptoms or signs of any pituitary insufficiency otherwise. He does have some increased urination during the day and 2 or 3 times during the night, but no clear-cut increased thirst. I review in the record to see whether there was any evidence of complete or partial diabetes insipidus after the surgery, but I found none. The current history is not suggestive of DI, but this will be looked into.

The headaches persist. They are mostly now in the right side of the face and skull, and have been felt elsewhere and here not to be related to the pituitary tumor history or presence of it (and I agree).

He has been given, prior to starting Topamax, a course of Medrol Dosepak and took 40 mg 48 hours ago and the lesser amount later on, and still is in the process of the taper. I mention this because it will be of relevance in the testing that I wanted and could not obtain (a.m. serum cortisol for instance) and the possibility that a TSH be suppressed by the steroids.

CURRENT MEDICATIONS:
As per the current list, which I reviewed. No significant additions.

ALLERGIES:
NKA.

SYSTEMS REVIEW:
General: He feels generally well, although he does not exercise as much as he used to, but he is still actively working, driving a truck and occasionally mowing lawns.
HEENT: His visual fields are back to normal as per former visual fields, and I saw the report of it.

Cardiovascular: Negative.
Respiratory: Occasional bronchitis in the past.
GI: He does have some reflux and is taking a proton pump inhibitor for it.
GU: His libido is normal, although he occasionally has noted lesser quality of erections, but the overall function is still fine. He does have some increased urination during the day and some nocturia, and as well as dribbling, and will be seeing a urologist for it.
Musculoskeletal: Negative.
Neuro: The headaches. See Neurology note.

PAST MEDICAL/SURGICAL HISTORY
1. Resection of a pituitary macroadenoma August 2008.
2. Sinus surgery December 2008.
3. Jaw surgery right side.

Otherwise, he has had no major illnesses or surgeries.

SOCIAL HISTORY:
He is married, has one child. Does not smoke, and may have three alcoholic beverages a month at most.

FAMILY HISTORY:
There is no history of an active endocrinopathy.

VITAL SIGNS:
Height: 174.0 cm, Weight: 75.10 kg, BSA: 1.92 M2, BMI: 24.805 KG/M2

PHYSICAL EXAMINATION:
General: He looks well, healthy, with good muscle bulk (he used to exercise in this regard).
HEENT: Fundi benign. Visual fields normal upon confrontation.
Neck: The thyroid gland is normal in size and consistency.
Lymph Nodes: None palpable.
Cardiovascular: No carotid bruits. There is no edema. Heart normal.
Lungs: Clear to auscultation and percussion.
Abdomen: Negative.
Musculoskeletal: Normal.
Skin: There is no increased or decreased pigmentation. Good texture.
External Genitalia: Both testicles are normal in size and have a normal consistency as well.

IMPRESSION/REPORT/PLAN:
Diagnoses:
#1 History of a pituitary macroadenoma, resected.
Most likely intact pituitary function.

#2 Headaches, migraine syndrome.

#3 History of esophageal reflux, on therapy.

Plan and Counseling: I do not think that the headaches are related to the pituitary tumor which in fact is pretty much resected by now, although I suspect that there must be remnant in the cavernous sinus, as it was there to begin with, and I do not think the surgeon would have been able to resect it in that area.

To the best of my knowledge, there was not any increased production of any pituitary tumor to begin with. There was the transient suspicion of an abnormal IGF-1, but this was not confirmed, and the patient does not have any symptoms or signs that would be suggestive of acromegaly.

I will try to review here an a.m. bioavailable testosterone with an FSH, as well as another set of

growth hormones and IGF, and he will give in the fasting state, including fluids (12 hours), a sample for serum osmolality and urine osmolality, which I expect to be normal. Otherwise, I will comment further.

He is leaving this weekend, so I will not see him for a return visit, but I will send him not only this note but a further one with my comments regarding the laboratory data, so he can distribute the information among his physicians up North. I will most likely give him a telephone call as well to let him know about the results some time next week.

DD: 12/10/2009 09:55
DT: 12/10/2009 10:11
JOB#: 1483529

Original: RA:bms by jcm

Dr. Richard Olson, D.C.
308 5th Avenue
Fairbanks, Alaska 99701
(907) 456-2244

Patient Name: Justin Olsen

Date: Chart Notes:

9.16.08 hurt head, nk in military '04-'05, had pituitary tumor 8/07 removed Ft Lewis, WA — after surg — loss pn, has, jaw pn, nk pn

9/16/09 C1-7 T1-5

9/23/09

12/14/09 nk pn, paw Naturopath — will have MKT

12/22/09 "Feeling pretty good" went to Mayo Clinic: "migraines"

12/31/09 nk pn C1 ASRA C5,6 LPS T3-6

1/7/10 "not too good", nk stiff C1-5 T3-6

1/12/10 R jaw V. tight: tr pts, actr R masseter C1-5 RPS T3-5

1/21/10

1/25/10 nothing new C1-5 T4-6 biotr.

2/24/10 a lot of jaw pn/nk pn C1-5 T3-6: CMT, tr pts, activator

EXHIBIT 10
Page 103 of 106

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URAC ACCREDITED INDEPENDENT REVIEW ORGANIZATION

Independent Medical Review

To: Dennie Castillo
Alaska Teamster - Employer Welfare Trust
520 East 34th Avenue, Suite 107
Anchorage, AK 99503

Date: August 10, 2010

Review for:	**Patient Name:**	Justin Olsen
	Patient Id:	9591-3757
	Group Id:	Not Available
	Date of Birth:	June 17, 1982
	PeerPoint® Case #	2010-17188
Type of Review:	Medical Necessity of TMJ Surgery	
Review Request:	Specialist	

Physician Review:

Reviewed by a Board Certified Oral & Maxillofacial Surgeon

Materials Reviewed:

- Chart notes and correspondence from multiple providers
- Copies of x-rays

Summary of Clinical Course:

The patient is a 28-year-old male with complaints of headaches, facial pain, and occasional right-sided jaw pain. There are no complaints of masticatory or speech dysfunction, range of motion limitations or jaw locking. The patient underwent a unilateral partial right TMJ condylectomy for condylar hyperplasia and appears to have adapted well despite having a malocclusion. The patient began to develop the facial pain and severe headaches following a transoral approach for removal of a pituitary tumor.

Response to Referral Question(s):

1. Is the right TMJ reconstruction with total joint prostheses medically necessary for the patient?

No. The right TMJ reconstruction with total joint prostheses is not medically necessary. The patient's chief complaints are facial pain and headaches. He is not having any difficulties with his jaw range of motion or with chewing. He seems to respond fairly well to medical therapy, but he still has episodic relapses. His oral surgeon recommended orthodontics and possible orthognathic surgery to correct the patient's malocclusion. This appears to be a more appropriate

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procedure to address that portion of his problems. Usually, total TMJ replacement is recommended for patients with severe joint ankylosis, limited range of motion, and difficulty with chewing because of a severe TMJ disorder. This patient exhibits none of those qualifications.

2. Will the patient's pain be eliminated with surgery?

No. There is no proof that the proposed TMJ replacement will eliminate the patient's pain or headaches. His symptoms seem to have worsened after the removal of his pituitary gland. Up to that point, he was functioning well with a shortened and malformed right TMJ condyle. As mentioned before, he has normal jaw range of motion, normal diet, no weight loss and only mild TMJ pain. It does not appear that a total TMJ prosthesis is required in this instance. Also, the fees submitted should be unbundled and many are excessive.

Rationale / Source of Determination:

Please see the above responses for rationale specific to each question.

References:

1. Okeson J, ed. *Orofacial Pain: Guidelines for Assessment, Diagnosis and Management.* Chicago, IL: Quintessence; 1996.

2. National Institutes of Health (NIH). Technology Assessment Conference Statement - Management of Temporomandibular Disorders. Bethesda, MD: NIH; April 29-May 1, 1996.

Joseph Radakovich, D.M.D.
Board Certified in: Oral & Maxillofacial Surgery
License No: OR-D6195

S Freedman MD

August 10, 2010

Skip Freedman, M.D. **DATE**
Executive Medical Director
License No: OK-16677, TX-H1083, NC-200301113, MO-2003004295

EXHIBIT 10
Page 105 of 106

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HEALTHCARE MANAGEMENT

URAC
ACCREDITED
INDEPENDENT REVIEW

Independent Medical Review Services
Peer Specialty Reviewer Information

Name	Dr. Joseph J Radakovich
Year of Birth	1955
Specialty Board(s)	American Board of Oral and Maxillofacial Surgery
Medical School, Year of Degree	Oregon Health Science University, Dentistry, 1984
State License(s)	Oregon D6195
Type of Practice	Surgery - Oral; Maxillofacial
Medical Management Experience	AllMed Peer Reviewer, 2002 – present
American Professional Societies	American Association of Oral and Maxillofacial Surgery Western Society of Oral and Maxillofacial Surgery Oregon Society of Oral and Maxillofacial Surgery American Society of Dental Anesthesia American Dental Association
Honors, Awards, Appointments	Assistant Professor, Dept. of Oral and Maxillofacial Surgery, OHSU, School of Dentistry

NOTE: This information is strictly confidential. Peer information should only be released to patients or other third parties when state laws or regulations require the release of such information. All questions / concerns about reviews should be directed to AllMed's Medical Director at 800.400.9916.

EXHIBIT 10
Page 106 of 106